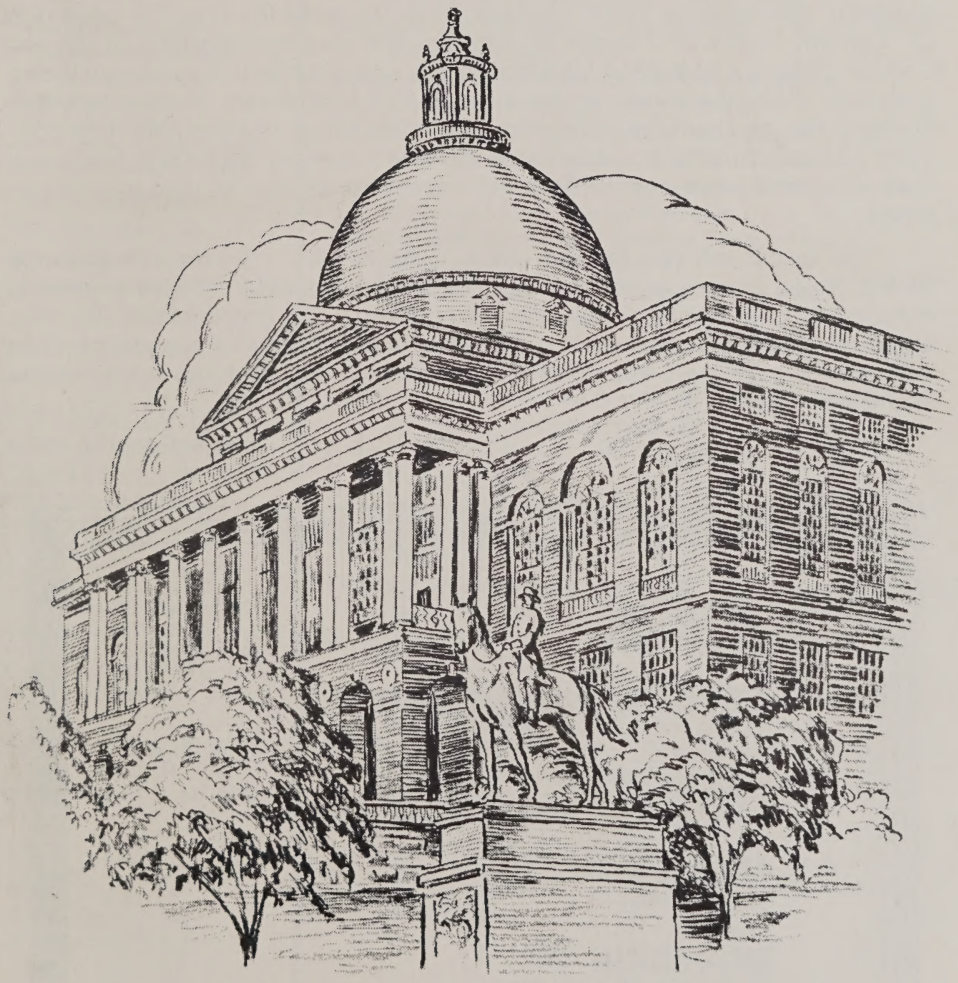
The Hampden Hippocrat

MARCH
1976



THE AMERICAN'S CREED

I believe in the United States of America as a government of the people, by the people, for the people; whose just powers are derived from the consent of the governed; a democracy in a republic, a sovereign Nation of many sovereign States; a perfect Union one and inseparable; established upon those principles of freedom, equality, justice and humanity for which American Patriots sacrificed their lives and fortunes. I therefore believe it is my duty to my country to love it, to support its Constitution, to obey its laws, to respect its flag, and to defend it against all enemies.

WILLIAM TYLER PAGE

INFORMATION: FOR THIS MONTH'S READERS

Again this month's theme will not be about the pending legislation in the Great and General Court. The bills and proposals have not as yet surfaced, so that your legislative councilor and chairmen can bring their analysis of the important issues and problems to be voted upon. Senator Sisitsky states his problems succinctly as does Representative Iris Holland. Your PR person is Dr. Bernard Bloom and herein he has brought you the highlights of the last Council meeting. I commend his article to you as it lists many of the issues facing organized medicine today at the state and federal levels. A plea by AMA Trustees Daniel Cloud for unification of all three levels should make you consider, if Massachusetts would be more effective in fighting Big Brother Medicine, if all physicians were contributing their resources as well as time from themselves.

You reader will also find an article in the series: Services Available to HDMS Physicians. A poem that appealed to the assistant Editor-in-chief is included as is an article on physician's hobbies. Drs. Sheffield and Zacarian are to be thanked for their continuing efforts to ferret out your avocations. Give them self help; let them know if you have a hobby, etc., and that you would be willing to write about it.

The Editor-in-chief

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Volume XXXII, No. 3 March 1976

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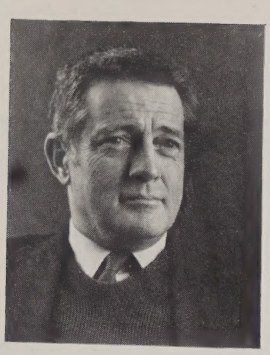

Gardner Cox II, M.D.

Your President's Page

TIMELY ADVICE

Fellows:

Now, more than ever, we need to think about continuing medical education. We need to plan our year mechanisms by which we can obtain with verification the fifty hours required by the A.M.A. Physicians Achievement Award and also increasingly required by the various boards, that is specialty boards for, continuance of their certifications. Those of you who attended the last District Medical Society meeting heard the suggestion by Dr. Alfano that this will be written into Malpractice insurance in the future as part of the requirements to obtain this insurance. The Mass Medical Society through its continuing medical education committee has set up mechanisms by which local hospitals can provide, for certain types of meetings, hourly credits. There are allowances for certain types of hourly credits for some of the tasks performed by men in hospitals and these should be looked into. These tasks need to be approved by the committee on continuing medical education or by the A.M.A. if you feel that the job fits in the categories defined. I am sure that the committee on medical education of the Mass Medical Society would be glad to furnish you with material covering the types of training that are approved and acceptable. As you know we have all recently paid a rather large sum, relatively, for licensing in the state of Massachusetts, and this board is new and may act to make CME a requirement for licensure. Some states already have this as part of their requirements and it is generally approved in principal by the profession.

I realize that all of you have very busy schedules, that all of us put off this type of involvement hoping that next month will be a better time, and the time slips by and we don't realize how long it's been since the last time. The fifty hours will probably become a yearly requirement and as we look at the next nine months I think it would be wise to plan it into your schedules so that it would be accomplished Your District Medical Society would be glad to try to supply you with whatever information they have available concerning programs near and far and it's there for the asking. You will find your names on mailing lists from the different postgraduate education areas that are actively participating with this type of review and it is available throughout the country at different times in all fields of medicine.

Think about it, plan ahead for it and begin to attend as it surely will be required in some form or another within the next year or two as part and parcel of your practice of Medicine in the future.

Gardner Cox II, M.D.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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Highlights of the Executive Committee Meeting

The HDMS Executive Committee met at 7:30 P.M. on Tuesday, February 24, 1976 in the Conference Room of the Society.

Present were Drs. Cox, Kelly, Kraus, Moore, Stoddard, Stoler, Teale, Trachtenberg, Walthall, and Mrs. Purdy.

Absent were Drs. Bloom, Lynn and Smith.

Dr. Fitzpatrick, Chairman of the Health Fair '76, was present to tell the committee about the proceedings of the fair. He reported that the fair is financially secure and advertising is proceeding well.

Dr. Boivin gave a report of the legislative meeting in Boston, in February. The Commonwealth's H #3160, which would give the Rate Setting Commission power to set hospital rates across the state will be aired at a hearing in Springfield on March 11, 1976. He spoke about Federal PL 93-641 (Health Planning & Resources Development Act of 1974) and the importance of physician participation.* An enacted NHI plan is not likely for the present Congress. Synopses of other pertinent legislation will be printed in a forthcoming issue of the *Hampden Hippocrat.*

Dr. Boivin was thanked for his report.

Dr. Stoddard read the minutes of the January meeting. The minutes were accepted as read.

Dr. Cox asked that New Business be brought up first as the budget for 1976-1977 was important and needed study and discussion.

The budget was presented to the members by Dr. Moore, Treasurer. It was itemized in detail and showed an 8% increase. After discussion and comment and upon motion duly made and seconded the committee voted to accept the budget, contingent upon its acceptance by the membership of the necessary dues increase at the April District meeting.

Two different complaints against two physicians were read and the committee voted to refer both cases to the Mediation Committee.

CORRESPONDENCE

WMHPC sent the "Standards of Guidelines for Patient Care in Nursing Homes." These will be turned over to the Public Health Committee and the next Newsletter will indicate that these standards are available for review at the HDMS office. Also available will be information from the Welfare Department about nursing homes.

The Maimonides Medical Club wrote informing the Executive Committee that a HDMS sponsored trip to Acapulco, Mexico, is not endorsed by that Club because of the recent vote by

* (Ed.: Refer to Jan '76 H.H. p. 18-R. J. Woolrich)

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Mexico in the United Nations to support a resolution that equated Zionism to racism. The committee voted to answer the President, Dr. Rosenbaum, and inform him that no HDMS member had indicated interest in this trip to Mexico and that the mailing was sent prior to the U.N. vote. The HDMS will no longer participate as a sponsor for such packaged trips to any country.

The Joint Commission on Accreditation of Hospitals informed the HDMS that both the Westfield Manor Nursing Home and the West Springfield Nursing Home have been accredited.

The A.M.A. Executive Vice President wrote informing the Executive Secretary about plans for seminars on "Negotiations." Such a seminar will be held at The Copley Plaza in Boston from March 26-28th. Further information will be printed in the next Newsletter.

The WMHPC is conducting an Ambulatory Care Study for the City of Springfield. Its findings will be given to the Public Health Committee for further study and highlights will appear in the Newsletter.

The A.M.A. sent an informational notation from its Public Affairs Division about the Health Manpower issue before Senator Kennedy's Committee. All physicians should write their U. S. Senators, refer to page 00 in this issue.

An informational letter from Dr. Tauber was read into the pages of the minutes in which he wrote to Representative Scibelli about welfare payments.

OLD BUSINESS

The Springfield Academy of Medicine and the HDMS will have their next joint meeting on December 7, 1976.

A letter from the MMS Ethics and Discipline Committee was read. It concurred with the decision of the HDMS Mediation Committee on a referred case.

The committee voted to allow Ch 57 to solicit the membership for the Action Auction for Ch. 57.

The Texas Medical Association has answered the HDMS letter, about the impact of the Garcia case on hospital-based physicians. Dr. Cox has asked that this issue be considered at Exec. Comm. March 16th meeting. It is quite involved and the Committee will study it before the meeting.

A letter from the Editor of the *Hampden Hippocrat* was read and discussed. The letter indicated that the H.H. Editorial Board felt the Editor would be more effective if he were a member of the Executive Committee. It was voted that the Editor not be a member of the Executive Committee. It was the opinion of the Executive Committee that, since the Public Relations Councilor is a member of the Executive Committee and since the present PR councilor is also a member of the Associate Editor Board, that positive action was unnecessary; in addition, the Secretary, Dr. Stoddard, is the Assistant Editor. A HDMS By-law change may be necessary to have the PR Councilor always be a member of both the Executive Committee and the editorial staff of the *Hampden Hippocrat.*

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An informational memo was read from the WMHPC on the merger of the Wesson Hospital and the Medical Center of Western Massachusetts.

The Burroughs Wellcome Co. wrote asking for the endorsement of the HDMS on their local television public service TV series. Upon motion duly made and seconded it was voted to endorse this program.

One other letter from a physician was referred to the Mediation Committee.

The meeting was adjourned at 10:30 P.M.

As submitted by
Philip B. Stoddard, M.D.
Secretary

* (Ed.: Refer to Jan. '76 H.H. p. 18—R. J. Woolrich)

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NOTICE:
Office of Continuing Education

The Medical College of Pennsylvania is accepting applications for the Fall 1976 session of its Retraining Program for Inactive Physicians, scheduled to begin on September 20th.

The program is seven weeks in duration and provides a review of general medicine for inactive physicians in order to enable their return to active practice of clinical medicine or to graduate training in clinical medicine. Included are a review of physical diagnostic skills, experience in clinical rotations, and a lecture series on general medicine, pathophysiology, diagnosis, and patient management.

There is no charge to participants for this program.

For further information and application contact: Retraining Program, Office of Continuing Education, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, Pennsylvania 19129.

Massachusetts Attempts to Answer the Malpractice Problem . . .

By State Representative Iris K. Holland

Nineteen hundred and seventy-five saw a crisis in medical malpractice sweeping the nation. Individual states lost control of malpractice insurance, and found themselves affected by trends in other jurisdictions over which they had little or no control. Certainly, this is the case in Massachusetts. Our crisis was precipitated by the decision of some insurance companies to withdraw from the malpractice market, by July 1, 1975, thus leaving many physicians and hospitals without insurance. The Legislature, however, stepped in and enacted Chapter 362 of the Acts of 1975 which effectively averted a serious crisis in malpractice insurance with its corresponding effect on the Commonwealth's health care delivery system.

Chapter 362 is a rather all-encompassing law, which goes beyond malpractice insurance and addresses the issue of medical malpractice itself.

1. To correct the problems of availability of insurance, a Joint Underwriting Association was created to provide malpractice insurance to any physician or hospital which is unable to obtain insurance on the open market. To date, approximately 6,000 physicians and surgeons and 75 hospitals are insured by the J.U.A.

2. To gain control over the rising insurance rates, the Commissioner of Insurance must fix and establish malpractice rates and classifications. This is an important reform. In fixing the rates the Commissioner must consider the insurance industry's investment income and their Massachusetts' experience. The Commissioner held a hearing as required by law and put a freeze on the rates for 1976 for doctors and hospitals for the following reasons:

   a) There existed considerable doubt about the validity of the data base and methodology employed by the Insurance Service Organization (a service organization which compiles malpractice data for most of the malpractice insurers and presents these filings to the Commissioner of Insurance as rate recommendations) in deriving their recommendations.

   b) The two advisory findings (I.S.O. and St. Paul Fire and Maine Insurance Company) recommend widely divergent rate levels for malpractice insurance for doctors (I.S.O. limits 100/300 for JUA = + 162.3%, St. Paul limits 100/300 for JUA = + 8.9%).

   c) It was the commissioner's opinion: "That neither of the advisory filings makes allowances for the effect of novel cost reducing factors introduced into malpractice insurance by Chapter 362 enacted in June 1975, which are not yet reflected in the past experience which forms the basis of their recommendations." The Commissioner's report also allows insurers (at their option) to reduce rates for doctors who are part-time. The insurance industry has ap-

next page

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pealed the Commissioner's decision to the Supreme Judicial Court.

3. To screen out non-meritorious malpractice suits a tribunal system has been created within the Superior Court. A tribunal will consist of a judge, lawyer and health care provider. The findings of the tribunal would be similar to a determination of probable cause; "whether the evidence presented, if properly substantiated is sufficient to raise a legitimate question of liability appropriate for Judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result." If the finding of the tribunal is against the plaintiff he must post a cash bond of at least $2,000. If the plaintiff loses in a subsequent trial, the bond would be forfeited and would be applied to defense costs including attorney and witness fees. In addition, the decision of the tribunal would be admissible as evidence in the subsequent trial.
4. Chapter 362 struck out the Ad Damnum clause, which eliminated a statement of the monetary amount being sought in the suit, in all proceedings for medical malpractice. Also the statute of limitations for minors would commence at age six and not eighteen.
5. Chapter 362 also established a new Board of Registration and Discipline in Medicine. The board will be financed by a biennial re-registration fee of $50.00. Re-registration is necessary since no existing agency, governmental or private, could give the exact number of registered physicians and surgeons in the Commonwealth. Tough disciplinary powers have been delegated to the board by Chapter 362. The board has the power to censure, suspend or revoke the license of any doctor who violates the rules and regulations of the Board.

Although Chapter 362 has solved our malpractice problems for now, the Legislature recognizes that problems will arise in the future. As a result, a Special Commission on Medical Malpractice was created. The commission consists of legislators, the Commissioner of Insurance and representatives of the Medical Profession, Bar, Hospitals, Insurance Industry and consumers. The commission is specifically mandated to monitor the effectiveness of Chapter 362 and to study the causes of the malpractice problem in Massachusetts. Specific areas to be studied are: the malpractice insurance industry's policies including their policy on investment income, whether and how present methods of regulating insurance companies should be modified; whether the establishment of a Joint Underwriting Association has had an impact on the availability and price of medical professional liability insurance in the Commonwealth; whether an examination of malpractice cases in the Commonwealth over at least the past ten years indicates that courts and juries have modified the classical definition of medical malpractice and that damage awards have been unjustifiably high; whether the limits on lawyer's contingency fees in medical malpractice cases is warranted; whether the imposition of ceilings on medical malpractice damage awards is warranted;

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whether claims handling policies of insurance companies have an effect on an aggrieved patient bringing suit; whether alternative approaches to the existing tort system is warranted; and whether the medical and legal professions have adequately discharged their obligations to the public to discipline their respective members who are guilty of medical malpractice or the unjustified institution of suit on the grounds of medical malpractice. The Commission is not limited to the above stated area and may expand its study to other areas of medical malpractice it deems relevant.

The Special Commission is organized and has begun its difficult work. Massachusetts has emerged from 1975 free of the medical malpractice problem which has affected the delivery of health care in some of our sister states. This is not to say, however, that we shall remain crisis-free, for even now the clouds of crises may be gathering on the horizon. We are more fortunate than most states, since we have the time to mold a permanent solution out of a very complex issue. The Special Commission is committed to finding an equitable solution for all who are affected by the malpractice problem.

Iris K. Holland
Representative 2nd District

Ed.'s Note: Iris K. Holland, State Rep., Second Hampden Dist., lives in Longmeadow. Her primary committee is the Legislative Committee on Health Care. She also serves as a member of the Special Commission for Medical Malpractice.

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Letter to Editor

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To The Editor:

To broaden my medical experience I would welcome the opportunity of spending two months working with an American physician in private practice. The federal regulations for medical studies in Germany require a two-month clerkship in an established practice as part of the medical study program. After passing the first stage of the medical exams (theoretical clinical subject) in the spring of 1976, I will spend a few months in a German medical practice. However, before continuing my studies I would like to acquaint myself with the American system of medical practice.

My interest and experience with the United States stems from working with American engineers at the Olympics, travelling to the United States on extensive business trips as well as on holidays and interpreting for a group of German engineers visiting several plants of IBM and RCA during 1973 and 1974.

Although I originally studied engineering, I have always had a keen interest in medicine through my father who is a pediatrician. Being aware of the problems in medical technology, I decided to also obtain an M.D. degree in order to work in medical and technical research in the future.

During my two months stay in the United States I will be financially independent and would appreciate an acknowledgment of my experience with you.

Yours truly,
Carl-Martin Kirsch

The American reference address is:

c/o Mr. William Huising
Juniper Lane—Box 308A
Southwick, MA 01077
Tel. (413) 569-5370

Editor's Note: An abbreviated C.V. is available at the HDMS office.

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From A Desk On Beacon Hill

by Alan D. Sisitsky

The 1970's have been a period where most of this country's institutions have been viewed with bitterness, skepticism and resentment by many of its citizens. Hardly a day goes by without attacks toward private owned public utilities or insurance companies for seemingly uncontrolled rate hikes; or big business for alleged bribes and pay-offs; or the judicial system for the staggering increase in the crime rate.

As one who is involved in politics, I am particularly sensitive to the public's resentment toward politicians. I recognize some politicians have reaped great benefits by being anti-government or anti-politician. The field of medicine has not remained sacrosanct from this cynical outlook of Americans and, in some respects, this development may be the most disturbing of all. Clearly the duties, aspirations and goals found in the field of medicine are certainly among the highest and idealistic of many in our society. Nevertheless, the business of medicine is the source of great public dissatisfaction.

Increased costs for hospitalization, health insurance premiums and laboratory tests have placed tremendous burdens upon the consumer and the blame is placed by them (whether justified or not) with the medical profession and private insurance companies. Doctors caught between soaring costs and cutbacks in Medicaid have been forced to reject patients dependent upon these programs. Such action can only generate increased dissatisfaction with both government and the medical profession.

The complexity of the problem is indeed staggering. There are increasing demands by my constituents for government to increase its control of all facets of medical service delivery. There appears to be similar themes touched upon when constituents contact my office. When lower-middle and middle class individuals can become penniless as a result of severe illness, or when poor people can be deprived of proper medical attention, then the call for greater government intervention will become more difficult to resist.

I believe the time has come for a more co-operative approach to resolving the problems of health care. If countries throughout the world can convene, despite various cultural backgrounds religions and political beliefs, at international conferences dealing with mutual interests then (certainly) we can bring together in some manner the varied and numerous elements which contribute toward delivery of health care in this country. When hospitals must absorb exorbitant costs for malpractice insurance and "defensive medicine," someone else eventually pays.

If subscribers cannot continue to meet the ever increasing health insurance premium rates, someone must absorb these bad debt losses when such an individual is unable to pay his or her bills. If private quality health care becomes available only to the very poor or very rich, society will assume the greatest debt of all.

It is imperative, therefore, that doctors, hospital administrators, consumers, advocates, legislators, insurance company representatives (from both the malpractice and health fields), and public health officials meet to map out creative strategies to improve the accessibility of quality medical care at costs which all income groups can afford. Those who desire the private sector to control the direction of health

(OVER PLEASE)

care in this country should welcome an opportunity to devise new mechanisms without additional governmental control. If conditions continue on their present course, however, public confidence in private enterprise's ability to handle its own affairs will decline and a renewed plea for state and federal intervention will be issued.

Those of us in government would also welcome an appropriate forum to discuss and explore various ways to assist the private sector in resolving the seemingly unreconcilable problem of controlling medical costs. The state's recent budget and tax crisis which has contributed to a loss in the public's confidence in our ability to lead, reminds us all too well of state government's limitation in solving social problems. Yet, a responsibility to the public need for reform may leave legislators little choice but to step into the treacherous waters of further private sector intervention.

Thus, we all have a stake at striking a balance of interest in this area—not only to alleviate these conflicting pressures between one segment of society and another—but also to restore the confidence and respect which has been lost during these turbulent years. A spirit of co-operation between these seemingly competing groups involved in medical care must become a reality. I submit that we may not be able to afford an alternative to co-operation.

The Honorable Alan D. Sisitsky
Senator to the Great & General Court
54 Draper Street
Springfield, Mass. 01108

Ed's Note: I agree wholeheartedly with Senator Sisitsky's conclusions.

NOTICE

20 February 1976

TO THE EDITOR:

Recent congressional action in relation to the Defense Appropriations Act has resulted in significant changes in the Civilian Health and Medical Program, Uniformed Services (CHAMPUS) that should be brought to your attention.

Effective 9 February 1976, all CHAMPUS beneficiaries who live within a 40-mile radius of a military or Public Health Hospital, must now go to that hospital for non-emergency inpatient care. Previously, certain CHAMPUS beneficiaries, such as retired and their dependents and active duty dependents who lived apart from their sponsor, were permitted freedom of choice to go to a civilian hospital or the military hospital without the requirement to get a certificate of non-availability. Also, the 40-mile radius is a change from the previous

(OVER)

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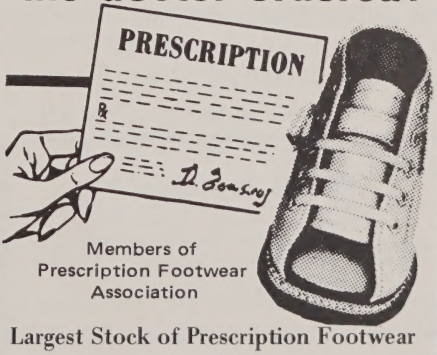

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30 miles. The mileage must be measured in air miles rather than road miles and so in reality, some beneficiaries may have to travel as much as 50 or 60 road miles to get to a hospital that is within 40 air nautical miles of their home. In this regard, the 40-mile radius of Cutler Army Hospital extends in a circle that goes just above Concord, New Hampshire in the north, Newburyport on the Northeast Coast, just South of Brockton, Massachusetts, includes Central Falls, Rhode Island and Turners Falls in the West. Since there are military hospitals at Pease Air Force Base in New Hampshire and Newport, Rhode Island and New London, Connecticut, practically any CHAMPUS beneficiary living between New Haven, Connecticut and Portland, Maine on the coast and roughly East of the Connecticut River in the West, up through Massachusetts, must now seek non-emergency in-patient care at the military hospitals mentioned or the Public Health Hospital in Brighton, MA.

Depending upon circumstances and the care available at the military or public health hospital, the hospital may issue a Non-Availability Statement which will allow the CHAMPUS beneficiary to receive the care at a civilian hospital on a cost-sharing basis. However, all beneficiaries living within the 40-mile radius will require a Non-Availability Statement to receive non-emergency in-patient care. No such certificate is needed for out-patient care.

Since these new requirements involve a considerable number of beneficiaries who initially may not be aware of them, this letter is being addressed to Medical Societies and Hospital Associations asking your help. Doctors treating affected CHAMPUS beneficiaries who recognize a need for non-emergency hospital care must inform the patient that they must seek such care in a military hospital or the public health hospital.

Your cooperation in this matter will be appreciated.

Sincerely,
Charles H. Wells, M.D., Col., MC
Commanding

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EDITORIAL:

The Tribunal System of Malpractice Hearings

Chapter 362 of the Acts of 1975 . . . "whether the evidence presented, if properly substantiated is sufficient to raise a legitimate question of liability appropriate for judicial inquiry or whether the plaintiff's case is merely an unfortunate medical result" . . .

This quotation from chapter 362 is the heart of the new Massachusetts Tribunal System and on the proper conduct by all parties hinges the point of success or failure for our unique pretrial evaluation of possible malpractice suits. Your Editor-in-chief had the honor to be selected as a member of a tribunal panel, which was convened recently by an esteemed Judge of the Commonwealth's Superior Court.

After a preliminary get together in the Judge's chambers, wherein he read selected exerpts from Chapter 362 (such as above) and a round of questioning to allow the three 'tribunees' to relate to one another and to absorp some of the importance of the occasion, the judge entered his court room followed by the lawyer and myself. We three sat before the bench, the hearing was convened and the charges and allegations read into the record. The judge then asked the plaintiff's lawyer to lay before us his client's case. Before the lawyer could speak, one of the lawyers representing the defense rose and asked for a new trial date, and he indicated that as he interpreted the new law, he and his client had not been properly notified of time, place and conditions. He was overruled in the discussion that followed. Then the second defense lawyer rose and also asked for a delay indicating he, too, was not prepared to move forward this day. Again the judge moved to push the case forward; he then returned to the plaintiff's lawyer with his original question. This lawyer rose and after some preliminary thoughts were read into the record indicated that he also wanted more time to prepare his case. He had been on the case two months. The judge then asked us other tribunees if we had any questions. The fact that we had not seen the particulars of the case was revealed and it was decided to provide us with copies. It now became apparent that the hearing could not continue and it was postponed to mid-May 1976.

Your Editor drove home wiser as to the ways of lawyers and the courts but saddened that so little had been

(NEXT PAGE)

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accomplished in an afternoon. An afternoon, in which seven individuals had been gathered to make the new Tribunal work and in which time and public funds were expended with little done to evaluate the merits of the plaintiff's case and to listen to the defense show why their clients were not guilty of malpractice or of producing an "unfortunate medical result." In the debates surrounding the creation of the Tribunal System, it had been developed that (on a projected basis) the Commonwealth may be faced with 3000 hearings a year. With about 200 court room days each year, it would be necessary to hear 15 cases per day; even 1000 cases of alleged malpractice would require 5 cases to be judged daily.

Accordingly it behooves the people involved in this Tribunal hearings to be ready to go on the day the case is called and that all parties be fully informed of the particulars of the case before entering the courtroom. In addition, because medical specialists are utilized as members of the tribunal panel (tribunees), related cases, either as to specialty or service rendered and now questioned, should be on the same day's docket. This would save time and money and speed up the system. With the proper evidence in front of it and each party geared to move ahead, a hearing should take no longer than two hours. The tribunees are not trying the cases, only listening and evaluating preliminary data and evidence so that they can "raise a legitimate question of liability . . . or whether the plaintiff's case is merely an unfortunate medical result."

I sincerely hope that when I return to Boston in May, that everything is in order to proceed forthwith. The alternative, if applicable to other hearings, would result in a legalistic slowdown and will wreck the workings of Chapter 362 and prevent a worthwhile advance in malpractice ajudication from proving itself. Each physician must make it known to his medical specialty society or to the Massachusetts Medical Society, that he or she stands ready to be a tribunee and is willing to judge his peers in a fair and impartial manner. The police state develops when society can not police itself. The lawyer tribunee also is selected by his state society for these purposes. The legislature must tighten the machinery of the new bill and move to ways which will expedite the entire hearing to a single court room session of perhaps two hours. If you agree, pass your ideas along to your state legislators—two of whom have written in this month's issue.

The Editor-in-chief

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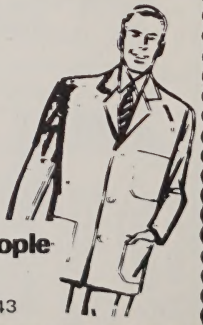

A Report to Membership

by Bernard Bloom, M.D.

The regular quarterly meeting of the Councilors of the MMS was held on February 11, 1976 at the Marriot Motor Hotel in Newton, Mass. The Council considered many important matters and the following notes are highlights as seen by your PR councilor:

A handout from the sub-committee on National Legislation stated that the National Health Planning and Resources Development Act of 1974 was an important piece of legislation and a *tremendous threat* to the delivery of Health Care under a free and selective system. It was felt that a summary of the law be published in district society newsletters. It is hoped that all members of the MMS have reviewed this law. Medical providers now face serious problems because of newly written regulations of the HEW relating to the Health Service Agency Act. Opinion was expressed that the "B" agencies (as a class) have been failures yet now they have controlling interest in all Federal monies allocated for health care in Massachusetts.

Another key item of business dealt with was "the relative value scale." The reporting committee felt that a relative value scale is in the best interest of the patient and does not represent a fee schedule and does not restrain competition or trade.

The next item of business concerned a resolution introduced by Dr. Gordon Lupien on May 21, 1975. There was considerable discussion and debate over this resolution.

The Committee on Legislation recommended that "restrictive covenants," which bar access of a physician locating in any towns, cities or other political sub-division, or from practicing in any hospital in which he has been granted staff privileges, are unethical and, "further be it resolved that the Council authorizes the Society to seek legislative remedy to cause such restrictive covenants to be unlawful." After considerable discussion this resolution was voted in the affirmative. The Legislative Committee also voted to seek relief from the 30% deduction in Medicaid payments to physicians retroactive to July 1, 1975. Action had occurred prior to the council meeting and agreement made with the Dept. of Public Health to the effect that Medicaid payments would be paid in full up to February 2, 1976. After this date the Medicaid payments will and have been cut 30%. However, the MMS has instituted legal proceedings and negotiations with the State to come to an accommodation to do away with this 30% deduction from fees allowed for treatment of Medicaid patients.

The Committee on By-Laws recommended that "those members who, regardless of category, hold a degree of doctor of medicine or doctor of osteopathy shall be known as fellows of the MMS." This recommendation was approved. The By-Laws committee further recommend that the MMS President should be "the Chief Executive Officer of the Society."

Ernest A. Byron, Jr.

SPRINGFIELD

Committee on Nominations stated the names of nominees should be accompanied by a published curriculum vitae so that the membership could vote intelligently on the individuals under consideration.

The Committee on Education announced that there will be a meeting April 14 at the Howard Johnson's Motel 57 in Boston to attempt to translate the work of Audit Committees into Education for the physician. This will be done with the cooperation of the Joint Committee on Accreditation and it promises to be a very interesting session.

The Judicial Committee brought up the subject of "referendums" to the membership. Any question affecting the Society may be referred to the voting members of the society for a general membership vote. Such questions shall be submitted to the fellows upon two thirds vote of the Council or written requests signed by 25% of the members of the Council or, written request signed by 5% of the Fellows. This was voted affirmatively by the Councilors.

A very extensive report on Professional Liability Insurance previously known as "malpractice insurance," was given by the committee chairman, Dr. Richard F. Gibbs. This lengthy report is contained in the circular of advanced information for Councilors. Dr. Gibbs received a rising vote of thanks for the arduous work involved in helping to accomplish the legislative setting up the JUA and providing for malpractice coverage for physicians in the Commonwealth. The Committee recommended that the MMS approve the formation of a physicians Insurance Company of Mass. at no incurred expense or liability to the Society. Such a company could be a catalyst to a free and competitive insurance market. There is much work still to be done on malpractice insurance and further reports from Dr. Gibbs will be forthcoming. A hand-out received at the meeting from JUA of Massachusetts should be carefully read by all HDMS members and was printed in the February issue of the HH. Dr. Gibbs stated that the new Board of Registration of Medicine and Discipline created by the Governor has been hampered by lack of funds and is referred to as "A poor Board." There is a need for new top notch investigative staff and personnel to carry out the functions of this new Board. Dr. Gibbs suggested that we write to our legislators stating that, although there has been a $50 fee for a two year period of registration and as a helping fund for the new Board, the funds have been restricted by the legislation so that the Board will find it difficult to carry on its intended work. It is recommended that we all write our legislators urging that more funds be made available for the proper functioning of the new Board of Registration and Discipline of Medicine.

cont. next page

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A request from Dr. Thomas J. Magill of HDMS was made for financial support of the Library of the Springfield Academy of Medicine. He proposed that a portion of the dues from the MMS be allocated to the S.A.M. (the sum of $3750) for the year 75-76 and thereafter. This resolution was defeated and instead a resolution was accepted to refer the issue to the MMS Educational Committee.

A request from the Interspecialty Committee, to make it a standing committee rather than a Special Committee, was defeated and the matter referred back to the Society for further consideration, after clarification of the need for making the Interspecialty Committee a standing committee.

A resolution had been submitted by Drs. Sidney Wanzer and Mary McDonald of Middlesex Central District Medical Society for consideration by the Council. It was resolved that smoking at Council meetings be permitted only in lobby areas outside the meeting room. This resolution was voted by the executive board, 12 for and three against. At the Council meeting the motion was carried and it is planned that from here on there will be no smoking at Council meetings in the meeting rooms.

The Councilors were addressed by Daniel T. Cloud, M.D., a pediatric surgeon from Phoenix, Arizona, who was elected to the Board of Trustees of the AMA in 1974. He gave a brief address on state of affairs of the AMA during the past several months. He stated that in June of 1974 the AMA had no cash reserve and had to go out and borrow three million dollars, because it was involved with deficit financing. It was necessary to continue borrowing until the financial crisis was recognized by the House of Delegates at the Portland meeting in December 1974. By making economies and cutting expenses, as well as raising the dues they were able to bring the AMA into a solvent position. At one point the AMA found itself with an eight million dollar deficit and no cash or liquid reserves. Effective January 1, 1976 the new dues structure will be $250 annually. The budget for 1976 is planned at 53 million dollars and it is hoped to put 10 million dollars in reserve to take care of contingencies requiring litigation, etc. It is hoped that the $250 dues would make unnecessary any further assessments, although Dr. Cloud noted that several million dollars had been collected in assessments previously made. He also made the point that if enough physicians were members of the AMA and paid dues the $250 new dues could be cut to $190 annually, so that it behooves us all to seek further membership from non-members of the AMA.

In regard to the recent series of five articles in the New York Times concerning "unnecessary surgery" in the U.S., Dr. Cloud commented on what the facts were and what the AMA has done to date. He stated that the House Sub-Committee Chairman, Rep. John E. Moss (Cal) had issued the report. He felt that many of the allegations made by the young persons on Mr. Moss' staff were misleading. He noted that in the February 9th AMA News there is an extensive article on this subject, as well as an editorial. The response made by the AMA has been (1) a strong letter to Mr. Moss by the Executive of the AMA, Dr. Sammons, stating that the facts were misleading and largely untrue. A letter was also sent to the New York Times and portions of this have already been pub-

(NEXT PAGE)

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lished. Finally, it attempted to get a correction report made by the House Sub-Committee's Chairman Mr. John Moss. The recent FTC complaint against the AMA made in December, 1975, in which a complaint was filed against the AMA, the New Haven County and Connecticut State Medical Society, stating that by prohibiting members from soliciting business they were interfering with freedom of competition. Dr. Cloud stated that surprisingly this matter had created more furor among physicians and caused more consolidation in physician attitudes and support than even the malpractice crisis that has hung over us for the past few years. It is felt by the AMA that such solicitation of patients by physicians would amount to hucksterism and would interfere with the high standards of professionalism physicians have enjoyed for centuries. The FTC had announced this suit at a press conference in Washington, D.C. *before* any of the organizations involved were informed about the matter. There was a pre-hearing the 25th of February in Washington, at which time the Council for the FTC and the AMA met. This is to be followed by a hearing before an Administrative Law Judge, after which there can be an appeal to the U.S. Circuit Court and if necessary an appeal to the U.S. Supreme Court. Dr. Cloud also noted that in Virginia a suit has been filed against the Virginia State Board of Medicine by the Comprehensive Health Planning Council, in reference to the establishment of a physician directory. In New York State the PIRG is suing the state Board of Regents in regard to a law defining unethical conduct of physicians.

Dr. Cloud then went on to "malpractice problems" throughout the country, stating that the worst problems still exist in the State of California. It is interesting to note that California is one of the six "unified states" with AMA membership mandatory at the State and County level. Dr. Cloud lamented that there are 3400 physicians in Massachusetts who are members of the AMA out of a total of 12,000 physicians in the state. This is one of the problems in keeping the AMA solvent and equally active throughout the 50 states. There are 100,000 physicians who do not belong to the AMA. On the positive side, 80 to 85% practicing physicians do belong to the AMA. He stressed that there is a need for unification, meaning that the physician belongs to his District or County Society, to his State, and also that he be a dues-paying member of the AMA. Dr. Cloud hoped that more states would unify, as the need for concerted action by physicians through the AMA would be better understood by the 100,000 physicians who are not dues-paying members of the AMA.

Bernard Bloom, M.D.
Massachusetts Medical Society Councilor
of Hampden District Medical Society

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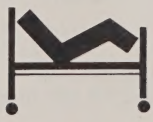

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by F. G. Mills, M.D.

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I started flying in 1965, and my enthusiasm for the sport has grown steadily since taking my first lesson at Barnes Airport, Westfield, in a Cessna airplane. With our wings, my wife, Isabelle, and our children have enjoyed many pleasant "mini vacations" over the past ten years, and in the past four years even our poodle Babette goes along—and enjoys it!

Some of our most pleasant trips have been to Nantucket, Martha's Vineyard and Cape Cod during the summer months when traveling by car could easily take four to eight hours on way, and we can reach any part of the shore within fifty minutes. This of course makes it possible to fly down—swim, picnic, go sight seeing or whatever, and return the same day without the fatigue of a very long and irritating drive in long lines of traffic. We have often thought of how nice it is when flying home in cool comfort—looking down on ribbons of cars stretched out for miles on the turnpike returning home from a weekend.

Other seasons of the year hold interest also. In the autumn the panorama of colors seen covering the landscape from the vantage point of an airplane is a breathtaking sight. We have enjoyed flying to Quebec early in the morning—having breakfast at the Chateau Frontenac—overlooking the St. Lawrence, spending a happy day seeing the local area, then returning home in the evening with fresh French Bread tucked under our arms.

Last year a family picnic on the St. Lawrence near Watertown, N.Y. was made possible on a weekend by means of the plane. Our children saw relatives they did not even remember from infrequent visits in years past.

The children were (and still are) able to visit colleges scattered over a large area, before making a choice of their foster home for four years, and as parents we have enjoyed seeing the campuses with them.

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Frank G. Mills, M.D. F.A.C.S.
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AMA

Manpower Legislation — Yes or No?

— American Medical Association, Legislation Department, Public Affairs Division—

The Senate Subcommittee on Health is expected shortly to consider manpower legislation presently pending before it. Hearings have been completed, and mark-up sessions of the Subcommittee could take place soon after Congress reconvenes January 19th.

The House has already passed its manpower bill, H.R. 5546, and this bill, along with several other major Senate proposals, is before the Subcommittee. Subsequent to the Senate hearings the Administration introduced its proposal.

The AMA appeared at hearings before the Senate Subcommittee (Kennedy Subcommittee) November 18, 1975.* Many of the elements listed below and covered in detail in AMA's testimony are common to several proposals.

In its testimony the AMA advocated that a manpower bill *should include:*

—construction loans and grants for medical schools
—capitation grants to medical schools
—assistance for a broad (rather than categorical) project grant authority
—loans and scholarships to medical students (including the programs for scholarships for the poor and disadvantaged)
—the National Health Service Corps program
—the Public Health and National Health Service Corps Scholarship Program
—assistance for family practice (to foster the development of primary care physicians)
—assistance for allied health personnel training
—assistance for public health training
—start-up and financial distress grants

In its testimony the AMA voiced strong objections to features it found to be unwise and detrimental to sound legislation. Particularly

(OVER)

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objectionable were those involving (1) unnecessary provisions to control residency training programs (2) mandatory service of students, (3) punitive payback provisions imposed on students, and (4) federal licensure.

The AMA urges that manpower legislation *should not include*:

—Provisions imposing conditions on capitation grants to medical schools such as
  1. Mandatory service for students, or
  2. Mandatory payback by *students* of aid given to the medical *school* (forced loan provisions)

—Provisions imposing mandatory federal service (including military service) on students as a condition for medical school admission

—Provisions initiating a Federal plan creating controls over residency training programs

—Provisions creating *punitive* payback requirements for student scholarship and service obligations, such as
  1. *Double payback* of amount of scholarship and other educational support funds received by the student. (Instead, reasonable payback requirements, with interest, could apply.)
  2. *Loss or denial* of license as a physician

—Provisions creating federal licensure and relicensure of physicians

—Provisions eliminating the current role of the State and local medical societies in certifying areas of need for assignment of National Health Service Corps personnel

The beneficial effects of past and existing manpower legislation in producing increased numbers of health personnel are now clearly evident. The increases, both in total numbers of medical students and graduates, have been *phenomenal.* The increase in numbers of physicians entering primary care residencies has been dramatic—to the point even where *58%* of 1974 medical school graduates entered residencies in the *primary care fields.* All evidence indicates this is a continuing and accelerating trend.

Too, the National Health Service Corps and other existing voluntary service obligations are placing increasing numbers of health personnel in shortage areas.

The foregoing objectionable provisions creating compulsory and punitive conditions upon medical schools and students are unwise and unnecessary and should be rejected.

January 16, 1976

*AMA statement presented November 18, 1975 to Subcommittee on Health, Committee on Labor and Public Welfare, U. S. Senate.

—American Medical Association, Legislation Department, Public Affairs Division—

The Ghost of Freedoms Past

Assistant Editor's Note:
An appropriate poem to ponder this 3rd month of the Bicentennial year — 1976.

As a first class citizen, I'd rate
I've paid my taxes, pulled my weight.
Kept my conscience free from sin
Gone to church . . . least now and then.
With little leagues, I've learned to play,
I've suffered hours of PTA.
I've paid my bills, observed the laws
And given to many a deserving cause.

But politics was not my dish,
I'd rather golf, or hunt, or fish.
When I was asked by Mr. Pate
Would I support his candidate?
I said I'd sent a prior check
'Twas all a lie . . . but what the heck.
When called to work for Senator White
I said my schedule was too tight.

When precinct meetings rolled around
I said that I was leaving town.
When Party help was needed now
I said, "They're all crooks, anyhow."
Then when it came the time to vote
I spent the day out in my boat.
And life rolled on, day in day out
About my future, I'd no doubt.

Then one night while dreaming fast
I met the Ghost of Freedoms Past.
He led me from my snug, warm bed
To show me things that lay ahead.
He showed me faces, thin and bleak
On folk who toiled through endless week,
Meeting quotas, reaching goals
Living under strict controls.

He showed me children reared by State
Whose aim was to indoctrinate.
Empty churches stood forlorn
Worship outlawed, buildings torn.
The Halls of Congress sealed by rust
Ballot boxes collecting dust.

(NEXT PAGE)

He showed me life where fear was norm
All all were clad in uniform.

He said when scientific tests were made
My kids had been assigned a trade.
Their lives a drudge, a menial chore
They could aspire to nothing more.
I'd been assigned . . . he then decreed
To clinics where there was a need.
I'd have a bed and board and clothes
With coupons to exchange for those.

For such I'd file a six-part claim
But sign my number, not my name.
And serve each day without complaint.
The State had now become my Saint.
I pleaded then, "It can't be true
There must be something I can do."
He sadly paused and then he said
"My friend, Democracy is dead.

There's just no way for legal fights
The Courts are closed, and you've no rights.
You had a chance in seventy-five
To keep that marvelous thing alive.
You simply said 'The job's not mine.'
Now this is nineteen eighty-nine,
For all the world, you didn't care
While there were others waiting there.

To call your life style to a halt
You lost your freedoms by default.
You gave it up just inch by inch
Those activists . . . they had a cinch.
So here it is, no hope no joy
Don't cry on me . . . you blew it, boy!"
And just then, I awoke in sweat
But I recall that nightmare yet.

Of life, with which I could not cope
Devoid of dreams, devoid of hope.
Devoid of warmth, devoid of love
Devoid of guidance from above.
I saw the error of my ways
And I will spend my lasting days,
Preserving all that we can be
A nation proud and strong and free.

And like my forebears in the strife
I'll pledge my honor, fortune, life.
I'll hold my right to vote most dear
And with it, keep your future clear.
I'll work and give . . . support, oppose
This land won't fall to some of those,
Who want the things I saw that night
Who feel that socialism's right.

This was my lesson. It will last.
Learned from the Ghost of Freedoms Past.

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THE PAGE OF THE HDMS'S WOMAN'S AUXILIARY

The New Black Eagle Jazz band played to an enthusiastic sell-out crowd on March 7. Toe tapping and rave reviews were heard throughout the Opera House at the Yankee Pedlar. Thanks to Mrs. William Yorzyk for her efforts in bringing the band here. It was an enjoyable afternoon for those fortunate to get inside.

The Springfield Health Fair was held March 11 to 14 at the Civic Center. The Auxiliary Board voted to give the Medical Society $500 to assist in underwriting the cost of the fair. Mrs. Charles Leagus, who worked very hard throughout the year for the fair, saw her efforts rewarded. Mrs. Leagus wants to thank the Auxiliary members, Women's Division of the Chamber of Commerce, Keyette Club of Longmeadow High School, Voluntary Action Center, and the volunteer offices of Mercy and Wesson Hospitals, and the Medical Center of Western Massachusetts in assisting in staffing the fair. In all over 100 volunteers worked in the Fair Office, Medical History Booth, Information Booth and in showing films, and providing general floor coverage. Also, Mrs. Alonzo Sheffield who selected and secured films for the fair and Mrs. Walter Mozden who coordinated the information booth are to be congratulated for an excellent job.

Mrs. Robert H. Nenninger
(Patricia)

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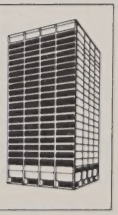

NO. 1

The Cancer Cooperative

by Edwin C. Thorn

SERIES ARTICLES:

Services available to HDMS Physicians

I should be wary of unsolicited questions, but unfortunately I am not that sophisticated. Recently your Editor, Dr. Stevens, asked if I could estimate, on the basis of activities to date, the percentage of accomplishment of The Cancer Cooperative's goals. After some rambling dissertation on my part, he said—"fine—would you write that for inclusion in next month's *Hippocrat.*" I welcomed the opportunity.

The Cancer Cooperative is a valuable, local, and voluntary organization. Our program has one basic and over-riding goal, which simply put is to assist in developing a system of cancer care which will ensure every patient access to all of the services and resources available within our Western Massachusetts area.

The Cooperative is funded by a grant from the National Cancer Institute to the Sidney Farber Cancer Center in Boston, with the purpose of developing regional cancer management systems. Initial program development centered on the three acute care Springfield hospitals with a later intent to broaden the program to include other area hospitals. Today, membership of The Cooperative consists of eleven hospitals in the Connecticut Valley area.

Who is The Cooperative? Unfortunately that question is often asked and seems to imply that we must be some outside unfriendly organization. Nothing could be further from the truth. *You* are The Cooperative. Through your representation on the staffs of area hospitals and through your members' representation on committees of The Cooperative, you make The Cooperative. The goals, direction, and activities of this organization are directed by the local members. Staff of The Cooperative exist only to carry out the wishes of the local hospitals and physicians.

One of the unique strengths of the organization is its Board—Policy Board. It is composed of the administrator, a trustee, and a physician of each of the eleven member hospitals. This Board provides for equality among the membership but most importantly, recognizes the distinct and valuable attitudes of these three components to health care and hospital organization.

So what is The Cooperative doing? Several activities are on-going. Most obvious to the majority of physicians are its educational programs. Last Fall a full day program was offered titled, "Current Approaches To Cancer." This year the Oncology Grand Rounds were instituted at several local hospitals. Two major educational programs have been offered for professional nursing personnel. The Care and Treatment Committee has developed a Breast Cancer Staging format and a recommendation that member hospitals adopt staging of cancer as a medical staff requirement. A valuable but long-range program has been developed. A Central Tumor Registry is now functioning. Computerization of registry data will permit identification of cancer incidence in our area, elimination of duplication of registry data, and trends in patterns of care; all of which will permit hospitals and physicians to better manage cancer patients. The Cooperative was assisting Medical Center of Western Mass. and Wesson Memorial Hospital in the review of their proposals for addition of ultra high energy radiation therapy equipment. Additional equipment is needed in Western Mass. and we will work towards its being added to the region's resources.

next page

Quality assurance is an important function of The Cooperative. In no way will The Cooperative become "big brother," but by developing local standards for cancer care, the individual hospitals and medical staffs will be better able to demonstrate quality cancer care to others. The Oncology Nursing Committee, in addition tc developing educational programs, has developed Pain Management Guidelines for use by the member hospitals and is now working to develop uniform nursing audit criteria.

But, back to Dr. Stevens original question. Have we accomplished what we set out to do? We are working for you, maybe you should be the judge and tell us.

Member Hospitals

Cooley Dickinson Hospital
Farren Memorial Hospital
Franklin County Public Hospital
Holyoke Hospital
Ludlow Hospital
Medical Center of Western Mass.
Mercy Hospital
Noble Hospital
Providence Hospital
Wesson Memorial Hospital
Wing Memorial Hospital

The Cancer Cooperative Staff

Helen Auton, R.N.
Isaac Lewin, M.D.
Carol Nystrom
Edwin Thorn

Edwin C. Thorn—Project Coordinator
The Cancer Cooperative
Springfield, Mass.

NO. 2

Can A Computer Help Your Office?

by Carolyn Ledewitz

Major innovations in the computer industry and increased clerical workloads in doctors offices have finally brought the advantages of computer systems into the world of medical administration. Until recent years the costs of automating office billing were prohibitive to most physicians, and computer specialists had no systems tailored to the highly specialized needs of individual doctor's offices.

Group practices and complicated third party billing and reporting have created a high volume of record keeping in doctor's offices. Now the development of mini computers and specialized medical business systems have made sophisticated administration available to the physician at much lower costs.

High power, speedy computers are now manufactured in sizes as small as an executive desk. Files may be stored on magnetic disks as small as 45 rpm phonograph records. These are capable of holding thousands of words of information. Mini computers print out reports and bills at the rate of 50 *lines* per minute and faster. Data input can be keyed directly into the computers or may be transmitted to on or off location computers in a variety of ways.

Local marketing representatives from IBM have reported that their newest small computers should enable them to make new estimates for physicians practices with costs much lower than was possible with the hardware available a year ago.

If you do not purchase or rent a computer for your own office, it may be feasible to use the services of a system in another doctor's office or of a data processing bureau catering to the special needs of physicians.

New software (programs and program packages) have been developed to meet the needs of all physician specialties. Computer venders, user groups and specialized data processing service bureaus have designed complete systems for doctor's offices and in-hospital groups. They usually provide an analyst to do a study of your needs, assist in initial conversion and follow-up. cont. page 33

Participating in a Merger

by
Robert Emery, M.D.
President, Professional Staff
Medical Center of Western Massachusetts and
Garry Hough, III, M.D.
President, Medical Staff
Wesson Memorial Hospital

The decision of the trustees to merge the Medical Center of Western Massachusetts and the Wesson Memorial Hospital (*Hampden Hippocrat,* December, 1975) came as a surprise to the medical community. Subsequent to the announcement, the responsibility of soliciting, organizing and implementing the knowledge and desires of involved physicians had been delegated in part to the authors of this article, the presidents of the professional staffs of the two merging hospitals. It seems appropriate to outline these efforts to the medical community.

It should be emphasized that neither the current officers nor their electors anticipated this merger and its attendant responsibilities. Both authors were given the opportunity to consider the concept prior to its presentation to the respective corporators. Both of us feel that the new institution should improve medical care in the community and that cooperation should yield greater progress than the competitive approach of the past. Realizing these goals depends on the contributions of the staffs of both hospitals.

Although the Baystate Medical Center does not exist at this time, physician planning is already under way. The overall conduct of the merger is being directed by the Joint Committee on Consolidation, appointed by the trustees. The four physicians on this committee have found a receptive audience for their suggestions. Formal recommendations developed by existing staff committees, notably the Executive Committees, have, to date, been uniformly approved. As staff presidents, we have tried to keep the Executive Committees and the entire staff informed of issues evaluated by the Joint Committee on Consolidation. Special meetings have been held and written information distributed.

Two physician committees are actively working on the problem of integrating the two professional staffs. Ten physicians constitute the Bylaws Committee, which will construct a framework for functioning as a single staff. Eighteen physicians, four of these ex officio, form the Medical Issues and Priorities Committee, studying problems of staff and department consolidation and mechanisms for their solution. This concept originated with the Executive Committee of the Medical Center of Western Massachusetts. Although appointed by the Joint Committee on Consolidation, the committee also reports to the two staff Executive Committees.

The date of birth of the Baystate Medical Center is not far away, pending state approval. It is obvious that corporate merger will precede staff merger. That is, two medical staffs will exist in one hospital for some time. A third staff committee is being formed to allow unified staff action in appropriate areas during this transitional period. Called the Professional Staff Coordinating Council, it will consist of a portion of each medical Executive Committee. It will act for the two medical staffs in such areas as credentials; particularly new staff applications. This sphere of activity may well increase as integrated staff functions increase, but it will remain within the framework of present bylaws. When the other two committees have completed their work and a single professional staff exists, the Council will be replaced, probably by a single Executive Committee.

(OVER)

The time required to develop the structure for staff merger is unknown. Merger has been mandated by the trustees and the corporators, but the staffs have been delegated the task of recommending implementation at the staff level. Those physicians who have accepted appointment to these implementing committees deserve our appreciation. Other members of the medical staffs who wish to make recommendations for the success of this merger can do so through these committees or by direct communication to the authors. The trustees and administrators of the merging hospitals have shown their concern for the community and their willingness to listen to contributions from physicians. We should do no less. It is our patients who will be treated in Baystate Medical Center.

Robert Emery, M.D. and
Garry Hough, III, M.D.

COMPUTERS, cont.

Some of the features medical packages may include are patient billing, industrial billing, insurance and Medicare claims, Blue Shield Claims, workmen's compensation final reports, accounts receivable management, aging by account, statistical information on services rendered, daily audit and control, periodic histories of all transactions. Physicians have reported better payment performance from both insurance and patients.

If you are interested in investigating computer possibilities for your office, call a vendor or a medical service bureau. Be sure you have a thorough study done including long range projections. Should you decide to automate, it is very important that your entire staff be well oriented to the nature of the new system. Patient and personnel resistance, plus initial conversion confusion, can cause problems. Usually these are the biggest, if not the only problems, involved in taking advantage of the speed and versatility of today's computers.

Mrs. Howard Ledewitz (Carolyn)
Systems Analyst

NEWS RELEASE

SPRINGFIELD, MASSACHUSETTS—The Division of Continuing Education at Springfield Technical Community College has announced major new offerings in the field of Allied Health Science for their Spring 1976 semester.

The seven new courses being offered are designed primarily for individuals currently working in the health professions. However, former health services employees that wish to return to the job market, as well as the general public, may be interested in any of the new offerings.

The first of the new offerings is called *Career and Life Assessment.*

The second new course is *An Introduction to Community Services for Elders.*

Number 3, A *Conversational Spanish for Public Service Personnel* will be offered also.

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Module III—*Fundamentals of Respiratory Therapy for Health Personnel.*

The final course in the Allied Health Science Series being offered this Spring at STCC is called *Medical Law and Ethics for Health Personnel.*

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